

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

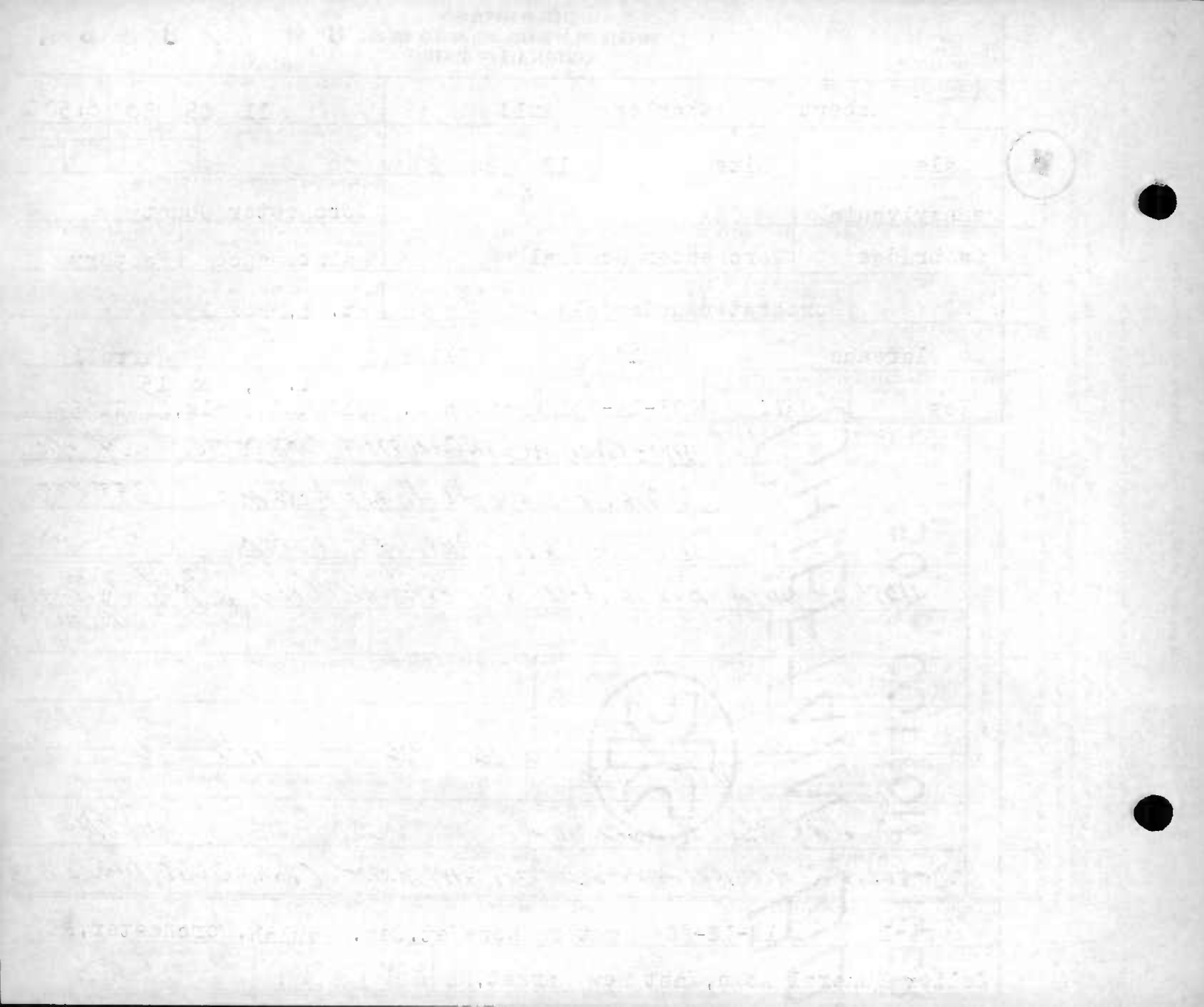
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 0 2 8 8 6 4									
1- FOR STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Charles Auld					2a. DATE OF DEATH MONTH DAY YEAR 11 08 80			2b. HOUR P M 6:50 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 26 23		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Factory	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Dorchester		13c. CITY OR TOWN Rhodesdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Auld			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Jarrell			13e. STREET ADDRESS Rt. 1, Box 158			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Martha A. Auld		ADDRESS Rt. 1, Box 158 MD 21659			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 MYOCARDIAL INFARCTION - STANDSTILL DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS SEV. 4 YRS SEV. 4 YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I HYPOTHERMIA DUE TO PROLONGED EXPOSURE TO COLD - BACK TO MYOCARDIAL									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 76 to 11/8 19 80, that (I) (we) lost saw the deceased alive on 11/8 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald R. McWilliams M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. McWILLIAMS, M.D.				22e. ADDRESS 308 GAY STREET CAMBRIDGE, MD. 21613					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-12-80		23c. NAME OF CEMETERY OR CREMATORY Eastern Shore Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Dorchester, MD			
24. FUNERAL DIRECTOR NAME Zeller Funeral Home, East New Market, MD				25a. DATE REC'D. BY REGISTRAR NOV 19 1980		25b. REGISTRAR'S SIGNATURE Doris K. Kellum			

BP \_\_\_\_\_

DHMH - 16 25M

(VR A 15 (4) 9/74



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 25M  
(VRA 15, 4) 1/79

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 8 8 6 5			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Della O BAYNARD				2a. DATE OF DEATH MONTH DAY YEAR 11 01 80		2b. HOUR 5:45 AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 09 09 90		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTERN SHORE HOSPITAL Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Talbot		13c. CITY OR TOWN Easton	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Ozman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Kemp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 218-34-7688A		17. INFORMANT ADDRESS M. Madison Baynard see item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 A SCVD & Cong Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Revascularized A.S. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bangrene of foot							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from Mar 4 <sup>th</sup> 19 73, to Mar 1 <sup>st</sup> 19 80, that (1) (we) last saw the deceased alive on 10/31 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Geo Beah MD				DEGREE		22c. DATE SIGNED 11/1/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE BEAH MD				22e. ADDRESS Rt 4, CAMBRIDGE, MD 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-4-80		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot Md.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR NOV 6 1980	
				25b. REGISTRAR'S SIGNATURE Rickey McCreedy			



Cambridge Eastern State Hospital Center

Dorchester

Female Department of Co. 10

PO

DELIA O. BARNARD

11 01 80 2 4

George W. Brown  
A.S. 12

ASVP & Corp. Home Police

Department of Post

X

10/21 10/21 10/21

GEORGE BROWN AND LESTER, CAMBRIDGE, MASS  
11/1/80

NOV 6 1980

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 8 6 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sarah Katherine Birch			2a. DATE OF DEATH MONTH DAY YEAR November 28, 1980		2b. HOUR A 12:30 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 27, 1903	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	12b. KIND OF BUSINESS OR INDUSTRY Hotel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Dorchester	13c. CITY OR TOWN Vienna	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Milton Wiley Sneed			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Green		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT ADDRESS Sugar Drive James Forester, East New Market, MD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>AS 1610</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Senility</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>MAHMOOD S. SHARIFF</i>	DEGREE	22c. DATE SIGNED 12-1-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAHMOOD S. SHARIFF	22e. ADDRESS 105 AURORA ST CAMBRIDGE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-2-80	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, MD
24. FUNERAL DIRECTOR NAME Zeller Funeral Home, East New Market MD		25a. DATE REC'D. BY REGISTRAR DEC 9 1980	25b. REGISTRAR'S SIGNATURE <i>Harvey McCready</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2  
retained by the hospital or attending physician.  
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

November 22, 1963

John F. Kennedy Library

Dear Sir:

Re:

November 22, 1963

Dear Sir:

Dear Sir:

November 22, 1963

Dear Sir:

Dear Sir:

November 22, 1963

Dear Sir:

Dear Sir:

November 22, 1963

Dear Sir:

Dear Sir:

Very truly yours,

John F. Kennedy

John F. Kennedy

John F. Kennedy

John F. Kennedy

Very truly yours,

John F. Kennedy

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Very truly yours,

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 80 28867				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER C. BODYCOMB, JR.					11/14/80				1:30 P. M.
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		10 03 07		73 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Dorchester MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		Dorchester General Hospital				Retired Engineer		Chemical	
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Maryland					Dorchester		Box 28		(Zip 21669)
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Walter Bodycomb, Sr.					Caroline Booth				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT (wife) ADDRESS		
no					145-10-6089		Mrs. Lois V. Bodycomb, same as 13 e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF b. <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF c. <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic pulmonary edema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
N/A		N/A							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		N/A		N/A					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
		N/A		N/A					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> 19 <u>80</u> , to <u>11/14</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Ullrich</u>					DEGREE		22c. DATE SIGNED <u>11/14/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>AR Wince</u>					22e. ADDRESS <u>400 Maryland Ave.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
burial		Nov. 18, 1980		Curran Reformed Church		Pompton Lakes, New Jersey			
24. FUNERAL DIRECTOR NAME <u>Curran Funeral Home, 308 High St., Cambridge</u>					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Anthony A. Brady</u>		
					Md. 21613				
					NOV 20 1980				

MEDICAL CERTIFICATION



Handwritten notes and stamps on lined paper, including a date stamp 'JAN 28 1953' and various illegible markings.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
M. Vernon Bolden Jr.								10/22/80								AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Negro	2-4-1924		56		MONTHS		DAYS		Oct. 22, 80						2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH						MD	
Md.		USA		WIDOWED		NEVER MARRIED		DIVORCED		Dorchester County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cambridge, Md.		Dorchester General Hospital		Laborer													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Caroline		Federalsburg		YES		NO									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
Vernon Benjamin Bolden		Bertha Ellen Tilghman															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		13-22-8476		Catherine Lewis													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Crushing wound of chest, Pulmonary embolus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		7 days							
8131		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)		DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
7:30AM/10/15/80		Passenger in car, in 2 car accident.															
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
Highway		U.S. Rt. 50 Nr. Linkwood, Dor. Md.															
22a. I certify that I took charge of the remains described above, held an Autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
John Mace Jr. M.D.		Deputy		10/27/80													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
John Mace Jr. M.D.		Cambridge, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		10/25/80		Cokesbury Cemetery		Dorchester, Md.											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Perry A. Reese North St. Milford, Del.						NOV 14 1980											



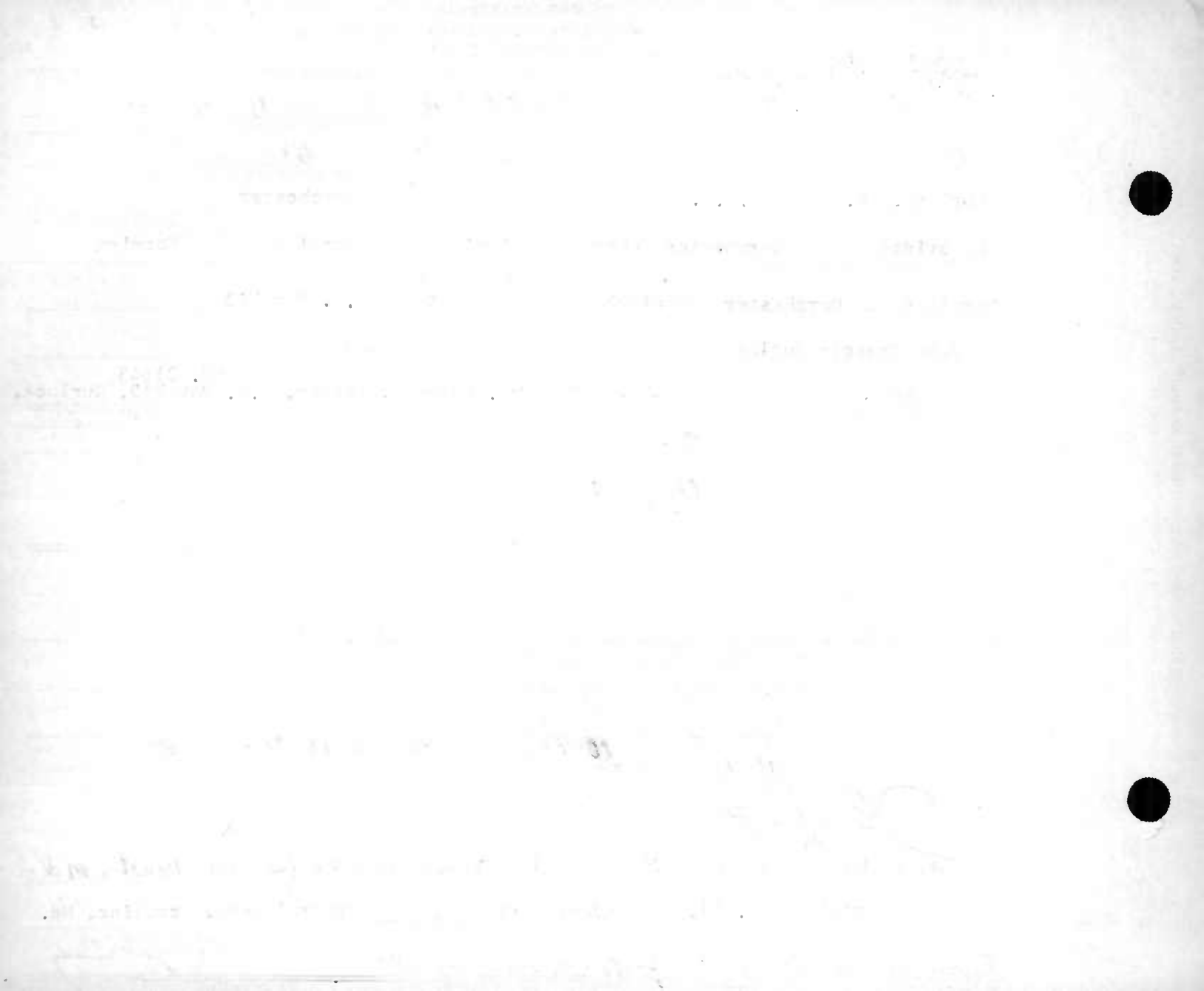
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR 1. STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>WILBERT LEON BUTLER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 7 80</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>3 3 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hurlock, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farming</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Dorchester</b>	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>P.O. Box 213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Francis Butler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lola Mae Adams</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-26-4593</b>	
17. INFORMANT ADDRESS <b>Md. 21643</b>		17b. Mrs. Helen M. Parker, P.O. Box 213, Hurlock,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EUA</b> <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-4-</b> 19 <b>80</b> , to <b>11-7-</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>11-7-</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>[Signature]</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. Edwin Fassett</b>		22e. ADDRESS <b>P.O. Box 213 Cambridge Md Dorchester, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 11, 1980</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Federalsburg, Caroline, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANKTON-HAWKINS</b>		25. DATE REC'D BY REGISTRAR <b>NOV 13 1980</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE PAGE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

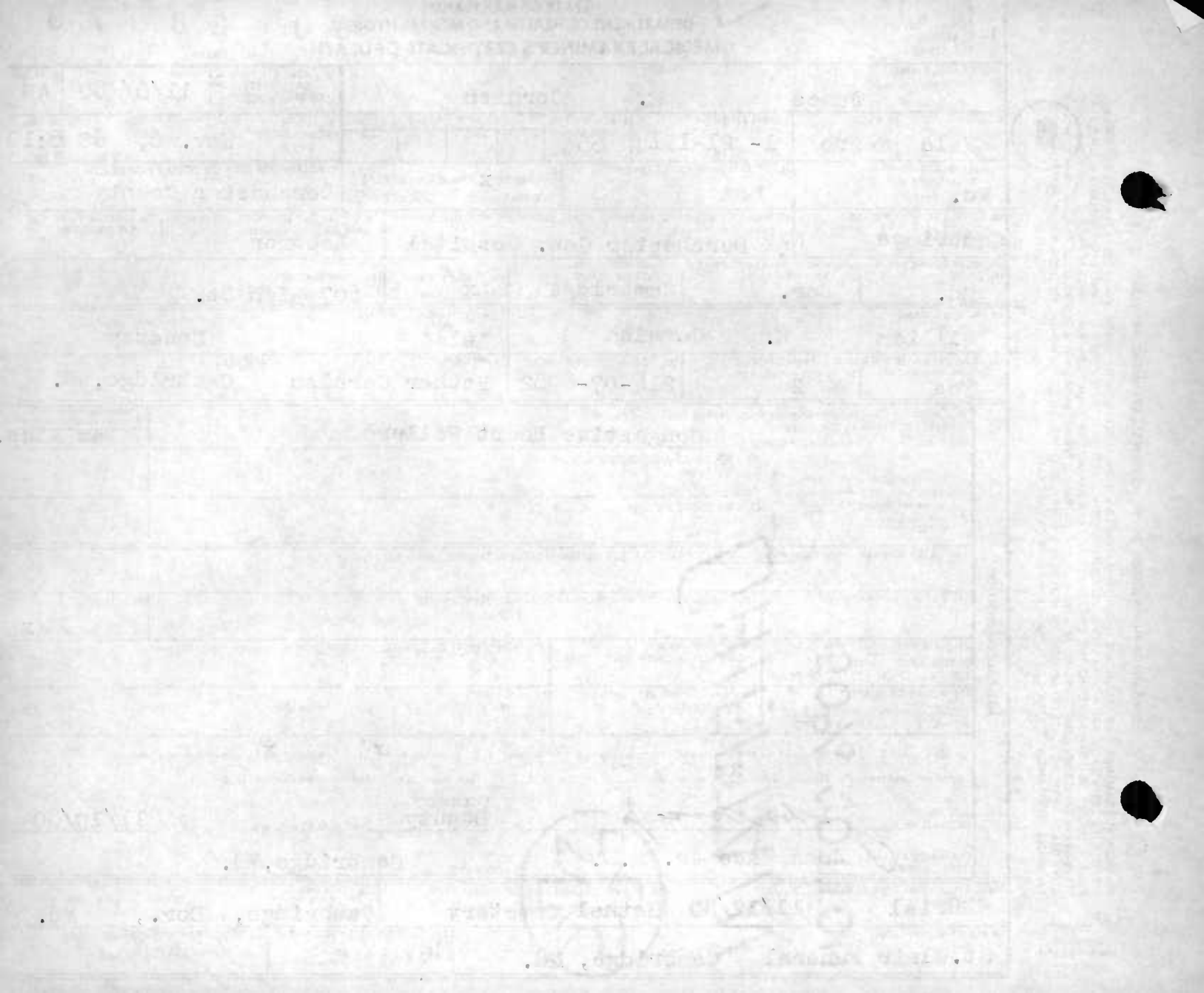
DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST James		MIDDLE E.		LAST Cornish		2a. DATE OF DEATH KNOWN ESTI- MATED		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY 11/6/80		2b. HOUR 19 AM	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 1-21-1914		6. AGE (IN YEARS) (LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR Nov. 6, 80		2d. HOUR 19 6:10 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County							
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Dorchester Gen. Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 607 High St.					
14. FATHER'S NAME FIRST MIDDLE LAST William E. Cornish				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Bonaway									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT Esther Cornish		ADDRESS Cambridge, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4280 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few mins.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John Mace Jr.				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 11/10/80	
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.				ADDRESS Cambridge, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/12/80		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery				23d. LOCATION CITY OR TOWN Cambridge, Dor.		COUNTY STATE Md.			
24. FUNERAL DIRECTOR NAME St. Clair Funeral				ADDRESS Cambridge, Md.				25. DATE REC'D. BY REGISTRAR NOV 14 1980		25b. REGISTRAR'S SIGNATURE R. J. McCreedy			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at a hospital, the certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.				8 0 2 8 8 7 1			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Mary Elsie DAIL				11 19 80		8 10		A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucas.		MONTH DAY YEAR 07 25 91		89		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				Dorchester			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Dorchester General Hospital		homemaker					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
Md. DORCHESTER		Cambridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Hudson, rural			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST William Rumbley		FIRST MIDDLE LAST Emma Marshall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		214-42-9739		son		Melvin Dail, Rt. 3, Box 162, Cambridge, Md. 21613			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Coronary Heart failure</u>									
4409									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Generalized atherosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Valvular heart disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) (this hospital) attended the deceased from <u>Nov 7, 19 80</u> to <u>Nov 19, 19 80</u> , that (2) (we) lost saw the deceased alive on <u>Nov 15, 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Michael A. Moskewicz MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11/19/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
MICHAEL A. MOSKEWICZ MD		503 134th ST CAM BRIDGE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATION		23d. LOCATION CITY OR TOWN COUNTY STATE			
burial		11/22/1980		Dorchester Mem. Pk.		Airey, Cambridge, Dor., Md.			
24. FUNERAL DIRECTOR		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Curran Funeral Home, 308 High St.		NOV 24 1980		Rising, R. R. R.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 8 8 7 2			
1- STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>ANNIE MARIE DYER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>11 18 80</b>			2b. HOUR <b>7 P M</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG 9, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DELAWARE</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD.							
12. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CAMBRIDGE HOUSE NURSING HOME</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>(RETIRED)</b>			15. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>				
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>CAROLINE GREENSBORO</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS <b>GENERAL DEL. GREENSBORO, MD</b>							
18. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM A. FLAMER</b>					19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMALINE (NMN) FLA</b>								
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		21. SOCIAL SECURITY NO. <b>NO</b>		22. INFORMANT ADDRESS <b>155-01-6747A RECRDS OF CAMBRIDGE HOUSE HOME.</b>									
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										24. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Organic Brain Syndrome</b>			
25a. DATE OF OPERATION <b>2 9</b>		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				26a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
28a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION STREET CITY OR TOWN COUNTY STATE									
29. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
29a. SIGNATURE <b>E. Tannan</b>				29b. DEGREE <b>MD</b>				29c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				29d. DATE SIGNED <b>11-18-80</b>	
30a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Tannan</b>				30b. ADDRESS <b>17 Franklin St. Cambridge, Md 21613</b>									
31a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		31b. DATE <b>11-22-1980</b>		31c. NAME OF CEMETERY OR CREMATORY <b>SANDTOWN CEMT</b>				31d. LOCATION CITY OR TOWN COUNTY STATE <b>HILLSBORO CAROLINE MD</b>					
32. FUNERAL DIRECTOR NAME <b>Hill Funeral Home</b>				32b. ADDRESS <b>GAY STREET DENTON, MD.</b>				32c. DATE REC'D BY REGISTRAR <b>11-18-80</b>				32d. SIGNATURE <b>[Signature]</b>	

BP

ANNIE WATKINS DYER

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GENERAL DEL. GREENSBORO

MAILING

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ORGL-SS-11

BP

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) David Odell Fletcher			2a. DATE KNOWN OF DEATH ESTIMATED 11 17 1980			2b. HOUR 8 AM		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 30. 1940	6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS 2 13	IF UNDER 1 YR. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD 11 17 1980		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County, MD.		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 505 Elm Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 505 Elm Street		
14. FATHER'S NAME FIRST MIDDLE LAST TERRIE LEE FLETCHER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS CARRY L. FLETCHER CAMBRIDGE, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Thomas D. Smith, M.D.			TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER					DATE SIGNED 11/18/80
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Rem. - Burial			23b. DATE 11/21/80		23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, Md.	
24. FUNERAL DIRECTOR NAME Frederick C. Smith			ADDRESS St. Clair Funeral Cambridge, Md.		25. DATE REC'D. BY REGISTRAR DEC 1 1980			





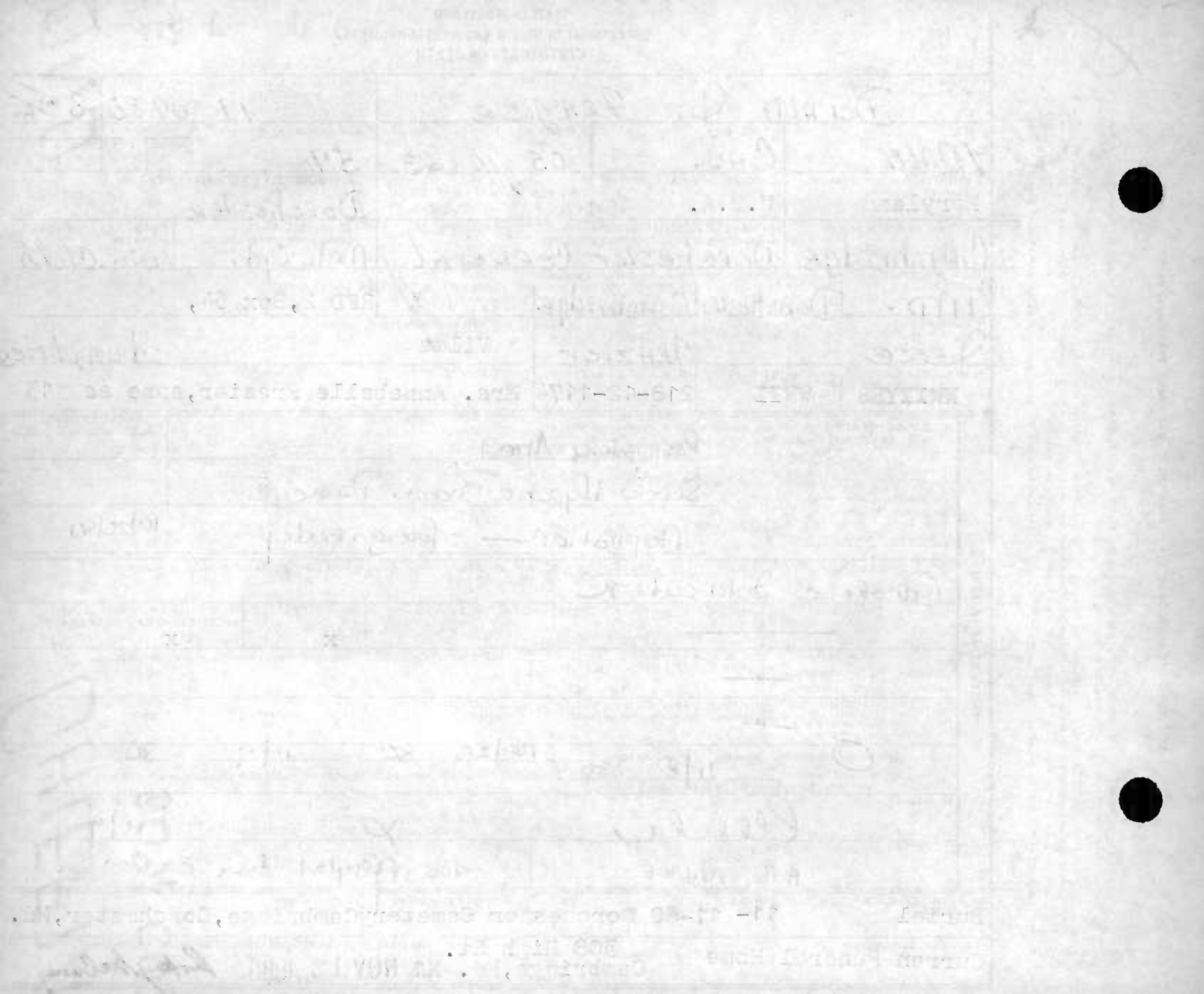
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>DONALD J. FRAZIER</b>					2a. DATE OF DEATH MONTH <b>11</b> DAY <b>09</b> YEAR <b>80</b>					
3. SEX <b>MALE</b>		4. RACE <b>CAU.</b>		5. DATE OF BIRTH MONTH <b>05</b> DAY <b>10</b> YEAR <b>23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		2b. HOUR <b>8 45</b> AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.				
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mch. Opt.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Wire Cloth</b>		
13a. STATE <b>MD.</b>					13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Jesse</b> MIDDLE <b>Frazier</b> LAST <b>Frazier</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Vilma</b> MIDDLE <b>Lumphries</b> LAST <b>Lumphries</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>XXXXXX</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>					16b. SOCIAL SECURITY NO. <b>218-12-1174</b>		17. INFORMANT ADDRESS <b>Mrs. Annabelle Frazier, same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>911°</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Hypoxic Brain Damage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aspiration - foreign body</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/25/80</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Alcoholic Intoxication</b>										
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> 19 <b>80</b> to <b>11/9</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11/8</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>AR Wilke</b>					22c. DATE SIGNED <b>11/9</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AR WILKE</b>					22e. ADDRESS <b>400 Maryland Ave</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>11-11-80</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Cemetery</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge, Dorchester, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Curran Funeral Home</b>					25a. DATE REC'D. BY REGISTRAR <b>21 NOV 12 1980</b>					
25b. REGISTRAR'S SIGNATURE <b>History McBrady</b>										

MEDICAL CERTIFICATION

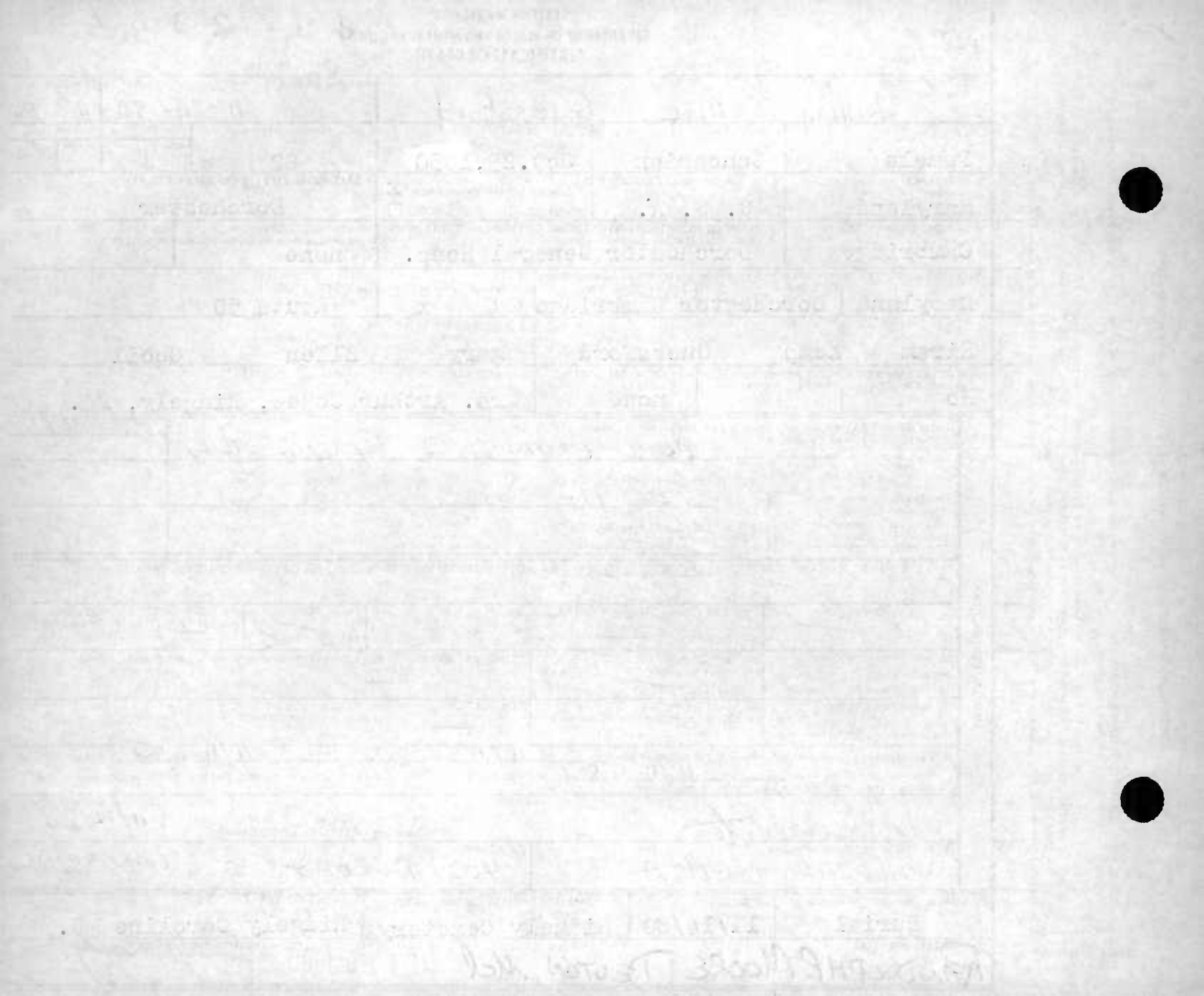


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lillian Mae Guessford</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>11 - 11 - 80</i>			2b. HOUR <i>10<sup>10</sup> PM</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 29, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD.				
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>none</i>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Dorchester</i>		13c. CITY OR TOWN <i>Cambridge</i>		13e. STREET ADDRESS <i>Route 50</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Hiram Kemp Guessford</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Ellen Cecil</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT ADDRESS <i>Mrs. Arthur Cohee, Ridgely, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Abdomen &amp; Perityphic Abscess</i> <i>4149</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sec. Hs. Dis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>O.B.S.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION <i>—</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>—</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/11</i> , 19 <i>80</i> , to <i>11/11</i> , 19 <i>80</i> , that (I) (we) lost the deceased alive on <i>11/11</i> , 19 <i>80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Vinodrai Mehta</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11/14/80</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>VINODRAI MEHTA</i>					22e. ADDRESS <i>400 AURORA ST. CAMBRIDGE</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>11/14/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ridgely Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Ridgely Caroline Md.</i>			
24. FUNERAL DIRECTOR NAME <i>RANDOLPH P. MOORE</i>					ADDRESS <i>TENTON, Md</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 19 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR  
Harold Spence

1. DECEASED NAME (TYPE OR PRINT) SPENCE H HAROLD			2a. DATE OF DEATH MONTH DAY YEAR 11 / 15 / 80		2b. HOUR 8:45 AM
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Holly Springs NC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		
10. CITY OR TOWN OF DEATH Cambridge, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Dorchester	13c. CITY OR TOWN Williamsburg	
14. FATHER'S NAME FIRST MIDDLE LAST Kemp Spence			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Cross		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS 10030 Annie Thomas, 25 Bradhurst Ave., NYC, NY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumophylosis &amp; Aspiration Pneumonia</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD &amp; Asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> 19 <u>80</u> , to <u>11/15</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>UINDRAI DEHTA</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/15/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) UINDRAI DEHTA			22e. ADDRESS 400 Aurora St Cambridge		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 24, 1980	23c. NAME OF CEMETERY OR CREMATORY Johns Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Preston, Caroline, Maryland	
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.			25a. DATE REC'D. BY REGISTRAR NOV 26 1980		

BP

DHMH-16 50M 7/77  
(VRA 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

Temple-Harding Funeral Home, 210 E. Main St.  
 Cedar Rapids, Iowa  
 May 24, 1980  
 Jones Cemetery  
 Boone, Iowa  
 1000

Annie Jones, 22 Broadway Ave., NYC, NY  
 10001

Francis Jones

Francis Jones

Box 133

Francis Jones

Francis Jones

Francis Jones

Francis Jones



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

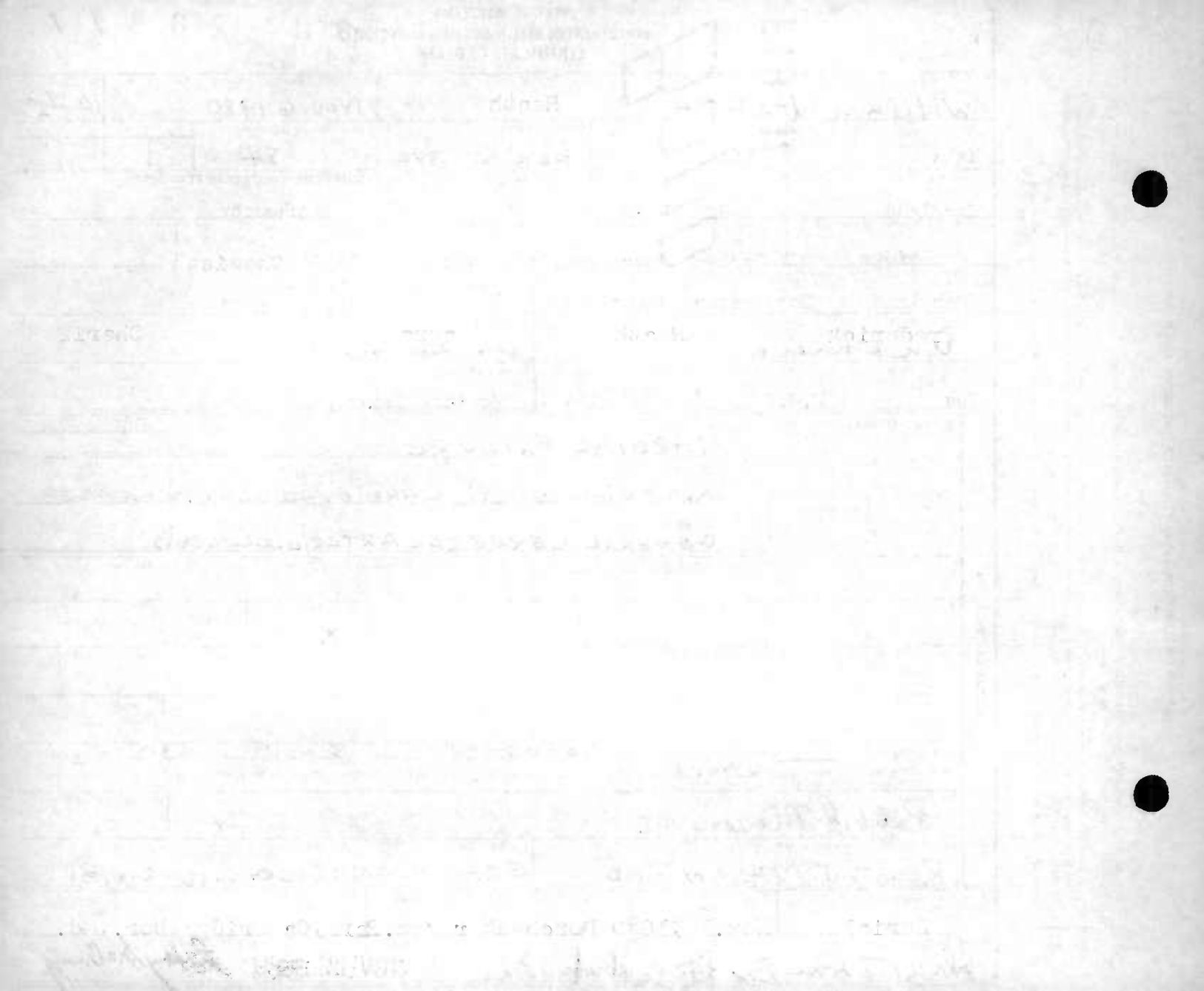
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/73  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 8 8 7 7	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>William H Edward</u> <u>Heath</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>Nov. 6. 1980</u>			2b. HOUR <u>10 19</u> A M			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>FEB 05 1896</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester</u> MD.					
10. CITY OR TOWN OF DEATH <u>Cambridge</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Eastern Shore Hospital Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired Chemist</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Dorchester</u>		13c. CITY OR TOWN <u>Cambridge</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Rte. 3, Box 24</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Frederick</u> <u>Heath</u> <u>Un Known</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Laura</u> <u>Sharif</u> <u>Un Known</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>			16b. SOCIAL SECURITY NO. <u>W.W.I</u> <u>088 05 1194</u>		17. INFORMANT ADDRESS <u>Medical Record, ESHC</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERAL CEREBRAL ARTERIOSCLEROSIS</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>03-07-80</u> , 19 <u>80</u> , to <u>6 Nov</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>6 Nov 80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robt. J. Mason, MD</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBT. J. MASON - MD</u>					22e. ADDRESS <u>ESHG - CAMBRIDGE, MD - 21613</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Nov. 10, 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park, Cambridge, Dor. Md.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR <u>John W. T. Loom Box 348 Cambridge, Md.</u>					25a. DATE REC'D. BY REGISTRAR <u>NOV 12 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Ruby Kennedy</u>				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 0 2 8 8 7 8				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Julian M. Hubbard</b>					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR
					11 18 80		10 45 P.M.		
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
				MONTH DAY YEAR		67 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DORCH COUNTY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD.			
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>DORCH</b> 13c. CITY OR TOWN <b>CAMB</b>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		507 ACADEMY ST		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST <b>RAYMOND</b> <b>HUBBARD</b>					FIRST MIDDLE LAST <b>FLOY</b> <b>MARSHALL</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>					16b. SOCIAL SECURITY NO. <b>22-18-6592</b>		17. INFORMANT ADDRESS <b>ROSALIE DITCHARD - 943-4206</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <b>MASSIVE INTRA CEREBRAL HEMORRHAGE</b>									<b>x 24 hrs</b>
4310 DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>11/17</b> , 19 <b>80</b> , to <b>11/18</b> , 19 <b>80</b> , that (1) (we) last saw the deceased alive on <b>11/18</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)									
22b. SIGNATURE <b>Hubert L. Fierzy MD</b>					DEGREE			22c. DATE SIGNED	
					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			<b>11/18/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUBERT L. FIERZY MD</b>					22e. ADDRESS <b>503 BYRN STREET CAMB. MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-21-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spedden-Seward Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hudson, Dorch. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Curran Funeral Home, Cambridge, Md.</b> ADDRESS <b>308 High St.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1980</b>		25b. REGISTRAR'S SIGNATURE <b>R. J. K. Cuddy</b>		

3



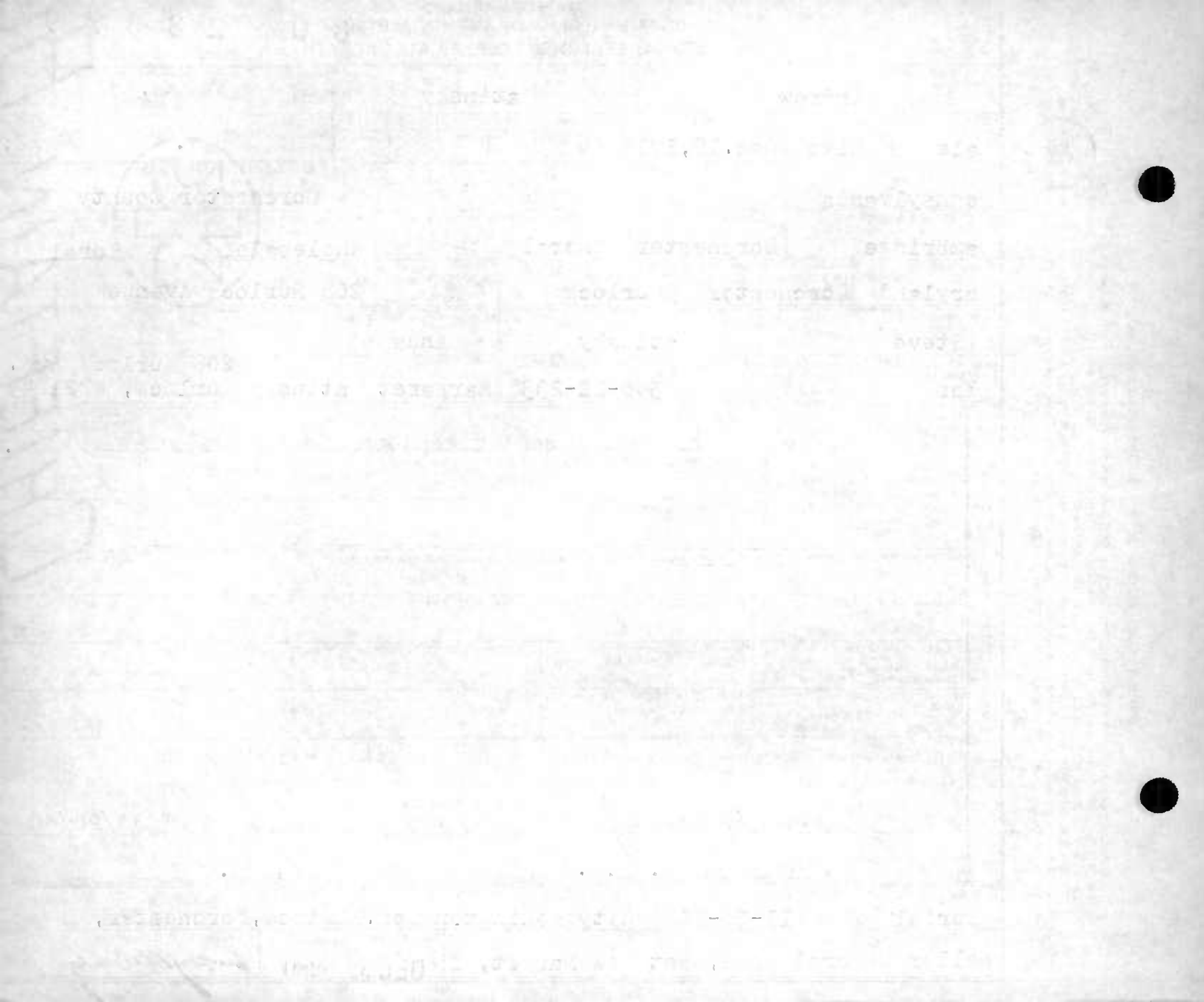


CHURCH BUREAU I HAVE, CO. 1000 N. 10th St.  
11-21-80 11-21-80 11-21-80 11-21-80 11-21-80 11-21-80 11-21-80 11-21-80 11-21-80 11-21-80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 28879	
1. DECEASED NAME (TYPE OR PRINT) <b>Andrew Katinsky</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>11/24/80</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 18, 1915</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>64</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>Nov. 24, 1980</b>	2d. HOUR <b>P.M.</b>		2e. HOUR <b>12:00</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b>					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wholesaler</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Floral</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Hurlock</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>208 Hurlock Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Steve Katinsky</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>546-22-2338</b>		17. INFORMANT ADD <b>208 Hurlock Ave.</b> <b>Margaret Katinsky Hurlock, MD 21643</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 4360 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few Mins.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John Mace Jr.</i>				TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>11/26/80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace Jr., M.D.</b>				ADDRESS <b>Cambridge, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-26-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Unity Washington Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hurlock, Dorchester, MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Zeller Funeral Home, East New Market, MD</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCurdy</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 8 8 8 0			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				3b. HOUR			
FIRST MIDDLE LAST Esta M. Lednum				MONTH DAY YEAR 11 21 80				5 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		MONTH DAY YEAR Feb. 5 1894		86 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Dorchester MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Dorchester General Hospital				Housewife					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.				Talbot		Tilghman		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Coopertown Road	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Sanuel A. Frampton				Margaret E. Clark							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				217-12-4081		Ira C. Lednum		714 August St. Easton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 5609 Intestinal Obstruction											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
A SCVD, Generalized arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
E. Tanman				MD				11-21-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
E. Tanman				17 Franklin St. Cambridge Md 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		11-24-80		Tilghman Methodist		Tilghman Talbot Md.					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home				Easton, Md.				NOV 25 1980 [Signature]			

MEDICAL CERTIFICATION





*Handwritten signature or mark at the bottom left corner.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	8	8	8	1
1 - FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>MARY E LEWIS</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>11-13-80</b>				2b. HOUR <b>1:13 A.M.</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>4 4 02</b>				6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester Co. MD.</b>								
10 CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester Gen. Hospital</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>505 Academy Street</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Cambridge</b>												
14. FATHER'S NAME FIRST MIDDLE LAST <b>John R. Clark</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Rigill</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO <b>220-26-0909</b>					17. INFORMANT ADDRESS <b>Gladys McWilliams 505 Academy St. Cambridge, Md.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> <b>4/149</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CORONARY HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS</b>																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>C.T. MORROW, MD</b>										DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/13/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.T. MORROW</b>										22e. ADDRESS <b>E.R., DORCH. GEN'L HOSP.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-15-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>E. New Mkt. Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>E. New Mkt, Dor. Md.</b>						
24. FUNERAL DIRECTOR NAME ADDRESS <b>Thomas Funeral Home Box 348 Maryland</b>										25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Rita A. Bandy</b>				

BP \_\_\_\_\_



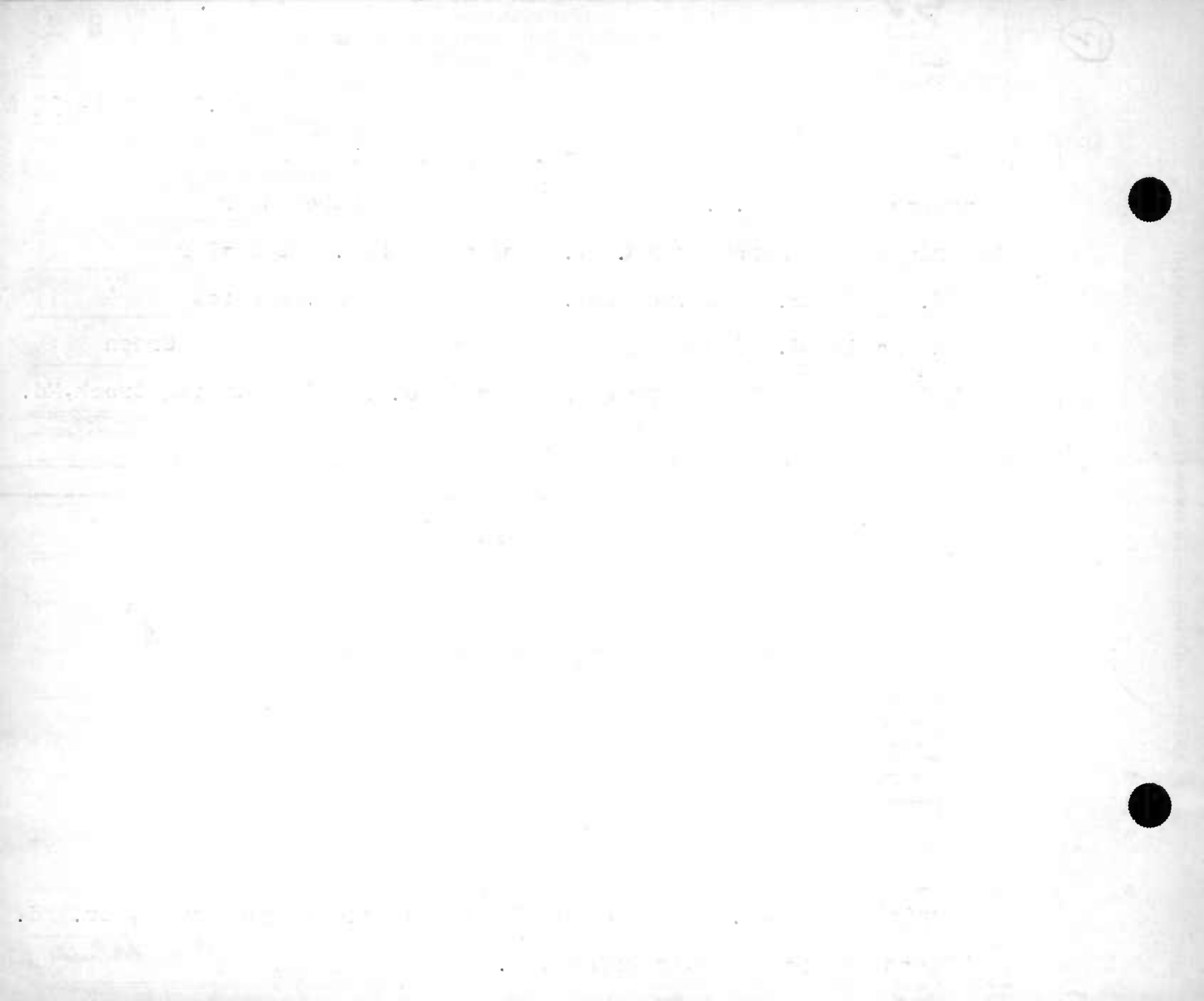
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	8	8	2
1. FOR REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Josiah Francis Linthicum										2a. DATE OF DEATH MONTH DAY YEAR Nov. 3, 1980				2b. HOUR 12:30 M A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 8 1892		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.									
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Genl. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Auto dealer		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Dor. Church Crk.										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 16 Rural			
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin J. Linthicum					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Green										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW 1 214-32-6858		17. INFORMANT ADDRESS Benjamin J. Linthicum, Church Creek, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.															
22b. SIGNATURE John A. Rudy MD										22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 5, 1980		23c. NAME OF CEMETERY OR CREMATORY Old Trinity Churchyard		23d. LOCATION (CITY OR TOWN) COUNTY STATE Church Creek, Dor., Md.									
24. FUNERAL DIRECTOR NAME ADDRESS Thomas Funeral Home, Cambridge, Md.,										25a. DATE REC'D. BY REGISTRAR NOV 5 1980		25b. REGISTRAR'S SIGNATURE P. A. Rudy			

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>HOWARD M. LYGT</b>			2a. DATE OF DEATH 11 Month 14 Day 80 Year			2b. HOUR M					
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>JAN-5-1896</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>DORCHESTER</b> Md.					
10. CITY OR TOWN OF DEATH <b>WILLIAMSBURG</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARK'S NURSE HOME CIVIL SERVICE</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>DOR</b>		13c. CITY OR TOWN <b>CONOVERVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD-3-BOX 101</b>		
14. FATHER'S NAME <b>ALEX - LYGT</b>			15. MOTHER'S MAIDEN NAME <b>JULIA - CROMWELL</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>179-05-1989</b>		17. INFORMANT Address <b>ERNEST LYGT RFD-3 #101</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4291</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Degenerative heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus electrolyte imbalance</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>8</b> - <b>1980</b> , to <b>11-14</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11-12</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. Edwin Fossett</b>		DEGREE <b>MD.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11-18-80</b>	
22d. PHYSICIAN'S NAME (Type) <b>J. Edwin Fossett</b>		22e. ADDRESS <b>P.O. Box 576 Conoverville Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11-17-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel A.M.E.</b>				23d. LOCATION (City or Town) (County) (State) <b>CAMB., DOR. MD.</b>			
24. FUNERAL DIRECTOR <b>L.H. BOARDLEY</b>				ADDRESS <b>CAMB., MD.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 24 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffery McBrady</b>	



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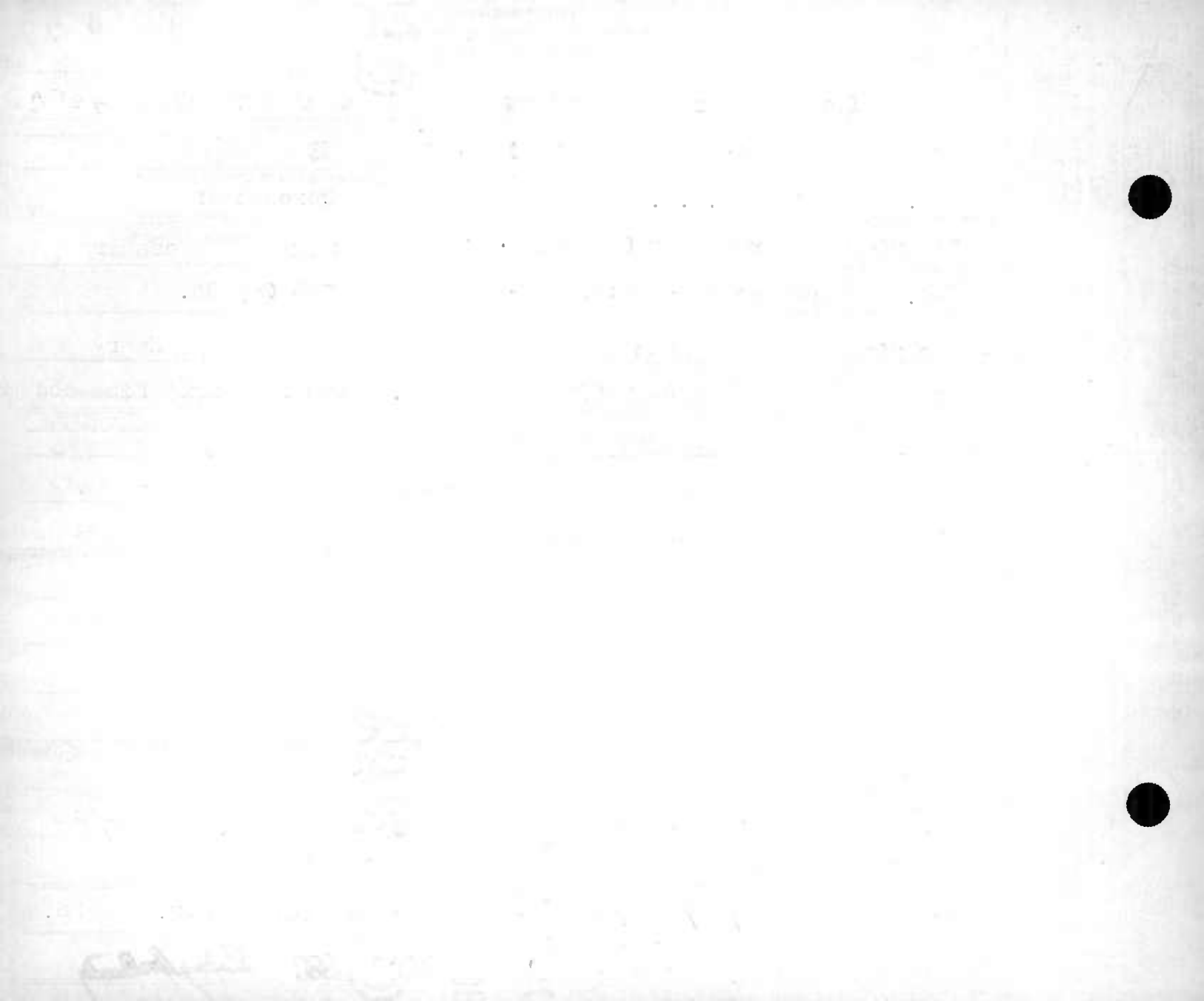


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 8 8 8 4	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Ida May Majors				2a. DATE OF DEATH MONTH DAY YEAR NOV 27, 1980				2b. HOUR 4:05 A M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR OCT 17 1887		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) worker		12b. KIND OF BUSINESS OR INDUSTRY cannery	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Dorchester Cambridge				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 304 Gay St.					
14. FATHER'S NAME FIRST MIDDLE LAST Ephriam Hassett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Ann Henry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO 214-07-9130		17. INFORMANT ADDRESS Kenneth H. Majors RD 1 Bx69 Linkwood MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SECONDS	
4360 } CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u>										DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEVERE ARTERIOSCLEROSIS</u>										YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CEREBROVASCULAR ACCIDENT</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21/80</u> , 19 <u>80</u> , to <u>11/27</u> , 19 <u>80</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>11/27</u> , 19 <u>80</u> , and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>C.T. Morrow</u> MD								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/27/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.T. MORROW								22e. ADDRESS EMORG. DEPT., DGH.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 11/29/80		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS T. G. MAS FUNERAL HOME 700 LOCUST ST CAMBRIDGE MD.								25a. DATE REC'D. BY REGISTRAR DEC 1 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>FRANCIS</b>			FIRST MIDDLE LAST <b>MARSHALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 3 80</b>			2b. HOUR <b>1 05 AM</b>		
3 SEX <b>MALE</b>		4 RACE <b>Cau</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 24 10</b>		6 AGE (IN YEARS (LAST BIRTHDAY)) <b>70</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD.					
10 CITY OR TOWN OF DEATH <b>Cambridge 2</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>EASTERN SHORE HOSPITAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>employed</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md</b>			13b. COUNTY <b>DORCHESTER</b>		13c. CITY OR TOWN <b>CAMBRIDGE 2</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>509 GAY STREET</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Robert S. Marshall</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Delia Parks</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>21848 6447</b>		17 INFORMANT ADDRESS <b>Cambridge Md. Eastern Shore Hosp Center</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>2501</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cholesterol Embolism, Ketoacidosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Generalized Atherosclerosis</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>11/3</b> 19 <b>80</b> to <b>11/3</b> 19 <b>80</b> , that (1) (we) lost above, the deceased alive on <b>11/3</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <b>E.D. DeLamater</b> DEGREE <b>MD</b>						22c. DATE SIGNED <b>11/3/80</b>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E.D. DeLamater, MD</b>						22f. ADDRESS <b>E.S.H.C. Cambridge Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-6-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge, Dorchester, Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Curran Funeral Home</b> ADDRESS <b>308 High Street Cambridge, Md.</b>						25. DATE REC'D. BY REGISTRAR <b>NOV 5 1980</b>			25b. REGISTRAR'S SIGNATURE <b>P. J. [Signature]</b>		

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Compound 5: 2-ethoxy-3-methyl-4-nitrophenol

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Wavelength (nm)

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11-12-1912

President John F. Kennedy

Genesee Waterworks

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Edward M. ...

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2100 De la Motte, Mrs. E. S. H. C. Cambridge Mass.

*[Faint handwritten signature]*

Item 6 g350 12/29/80 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

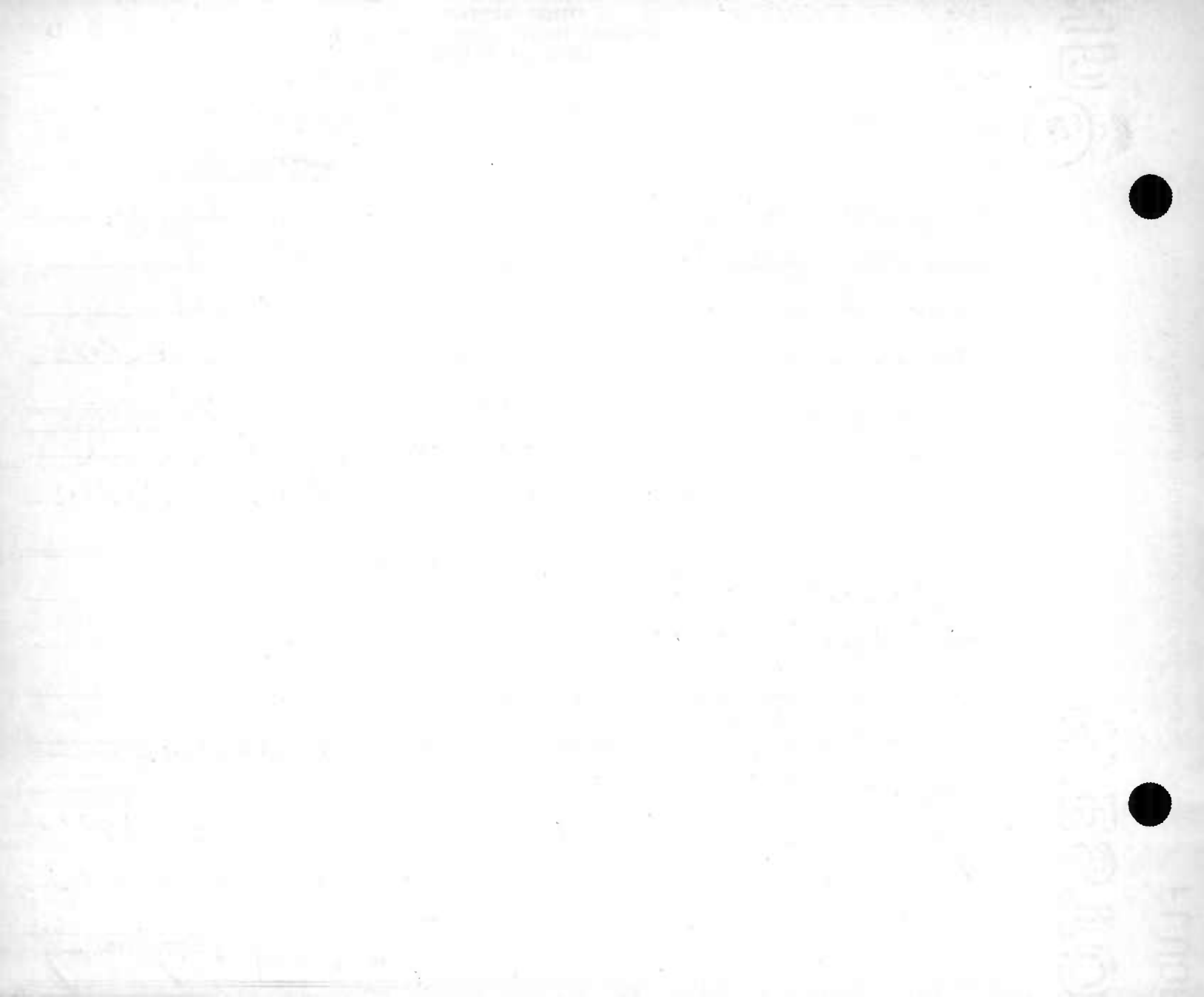
1. DECEASED NAME (TYPE OR PRINT) James A. Steele			2a. DATE OF DEATH MONTH DAY YEAR 11 - 25 - 80			2b. HOUR 2 30 PM				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11 - 5 - 14		6. AGE (IN YEARS LAST BIRTHDAY) 66 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? United States		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.				
12. CITY OR TOWN OF DEATH Cambridge		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN Trappe			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Carmel Steele			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Vickers			16. ADDRESS At. 1 Box 228				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 180-01-2549			17. INFORMANT Mrs. Leta E. Steele see item #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of common bile duct with metastases</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> 1561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION Mar 1979			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED above			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (1) [this hospital] attended the deceased from <u>Mar 79</u> to <u>Nov 25</u> 19 <u>80</u> , that (1) [we] lost saw the deceased alive on <u>Nov 25</u> 19 <u>80</u> , and that in [my] [our] opinion death occurred on the date and hour and from the causes stated above, (1) [we] [did] [did not] view the body after death.										
22a. SIGNATURE Lewis M. Burdette MD			DEGREE MD			22b. DATE SIGNED 11/25/80			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burdette			22e. ADDRESS 4 Aurora St Cambridge Md 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-28-80		23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d. LOCATION CITY OR TOWN Oxford		23e. COUNTY Talbot	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR DEC 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 8 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gertrude M. Taylor			2a. DATE OF DEATH MONTH DAY YEAR 11 28 80			2b. HOUR 105 PM								
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 05 24 18		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.				
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			10. CITIZEN OF WHAT COUNTRY? United States			11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			12. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
13. CITY OR TOWN OF DEATH Cambridge			14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food processor			16. KIND OF BUSINESS OR INDUSTRY Canning Co.					
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Maryland			17b. COUNTY Dorchester			17c. CITY OR TOWN E. New Market			17d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			17e. STREET ADDRESS Rt. 1, Box 91		
18. FATHER'S NAME FIRST MIDDLE LAST Moskoe Johnson			19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Stanley			20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			21. SOCIAL SECURITY NO. 220-28-1877			22. INFORMANT ADDRESS Anna M. Dockins, Rt. 1, Box 198A, Hebron, Md. 21830		

23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast cancer 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Generalized arteriosclerosis					
24. DATE OF OPERATION —		25. CONDITION FOR WHICH OPERATION WAS PERFORMED —		26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
30. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		32. LOCATION STREET CITY OR TOWN COUNTY STATE	
33. I certify that (1) (this hospital) attended the deceased from Dec 19 79, to Nov 28 19 80, that (1) (we) last saw the deceased alive on Nov 28 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.					
34. SIGNATURE Michael A. Moskewicz				35. DATE SIGNED 11/28/80	
36. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ				37. ADDRESS Box 43	

38. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		39. DATE Dec. 4, 1980		40. NAME OF CEMETERY OR CREMATORY Thompstontown C. metery		41. LOCATION CITY OR TOWN COUNTY STATE Thompstontown, Dorchester, Md.	
42. FUNERAL DIRECTOR NAME FRAMPTON HAWKINS F. H.		43. ADDRESS FEDERALSBURG		44. DATE RECEIVED BY DEC 9 1980		45. SIGNATURE [Signature]	



the first of the year

the first of the year

the first of the year

the first of the year

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M  
(VRA 15.4) 1/79

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 8 8 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ethel</b>		FIRST <b>Emmells</b>		MIDDLE <b>Turpin</b>		LAST		2a. DATE OF DEATH MONTH <b>11</b> YEAR <b>80</b>		2b. HOUR	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>6</b> YEAR <b>05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>25</b> YRS.		IF UNDER 1 YEAR MONTHS <b>25</b> DAYS <b>05</b>		IF UNDER 24 HRS HOURS <b>05</b> MIN <b>00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b>					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Eastern Shore Nav. Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>MD</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Preston</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route # 1 Box 151 C</b>			
14. FATHER'S NAME FIRST <b>—</b> MIDDLE <b>—</b> LAST <b>—</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ellen</b> MIDDLE <b>Cass</b> LAST <b>one</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>160-24-6037</b>		17. INFORMANT <b>Alfred</b>		ADDRESS <b>Turpin</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ISCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Carcinoma of sigmoid Colon is fistula to vagina</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Ed Dekanator</b>						DEGREE		22c. DATE SIGNED <b>11/6/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ed Dekanator, MD.</b>						22e. ADDRESS <b>ESHQ. Cambridge, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL <b>burial</b>		23b. DATE <b>11/12/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Richards</b>		23d. LOCATION CITY OR TOWN <b>Preston</b> COUNTY <b>TA</b> STATE <b>MD</b>					
24. FUNERAL DIRECTOR Name <b>James M. White</b> ADDRESS <b>Edinburg</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1980</b>		25b. REGISTRAR'S SIGNATURE <b>John McHenry</b>			



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1- FOR STATE REGISTRAR										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																																																											
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR																																																											
MICHAEL WESLEY TYLER										11-23-80										?																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.										7c. DATE PRONOUNCED DEAD										2d. HOUR									
MALE										WHITE										9/28/1948										32																														11-23-80										5P									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH																																																	
FLORIDA										U.S.A.										WIDOWED										DORCHESTER																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Secretary										Rt. 14										Sheet maker										Can Mfg.																																																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?										13b. STREET ADDRESS																																																											
Maryland										YES										Rt. 14, Box 271																																																											
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
Leon										Elsie																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																																																	
YES										217-54-7483										Mr. Leon W. Tyler										203 Linthicum																																																	
																														Cambridge, Md.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART I DEATH WAS CAUSED BY:																																																																															
IMMEDIATE CAUSE (a)																																																																															
Carbon Monoxide Poisoning																																																																															
DUE TO, OR AS A CONSEQUENCE OF																																																																															
(b)																																																																															
DUE TO, OR AS A CONSEQUENCE OF																																																																															
(c)																																																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																											
																				YES																																																											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																											
										11/23/80										Shut self in garage with motor running																																																											
21d. INJURY OCCURRED WHILE AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																																																											
NOT WHILE AT WORK										Garage										Rt. 14 Secretary Dor. Md.																																																											
22a. I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from:																																																																															
Natural causes										Accident										Suicide																																																											
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																											
John Mace Jr.										Deputy										11/25/80																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																					
John Mace Jr.										Cambridge, Md.																																																																					
23a. BURIAL, CREMATION, REMOVAL										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																																																	
Burial										11-26-80										Md. Veterans Cemetery										Beulah, Dorch. Md.																																																	
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
Curran Funeral Home										NOV 28 1980										[Signature]																																																											

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

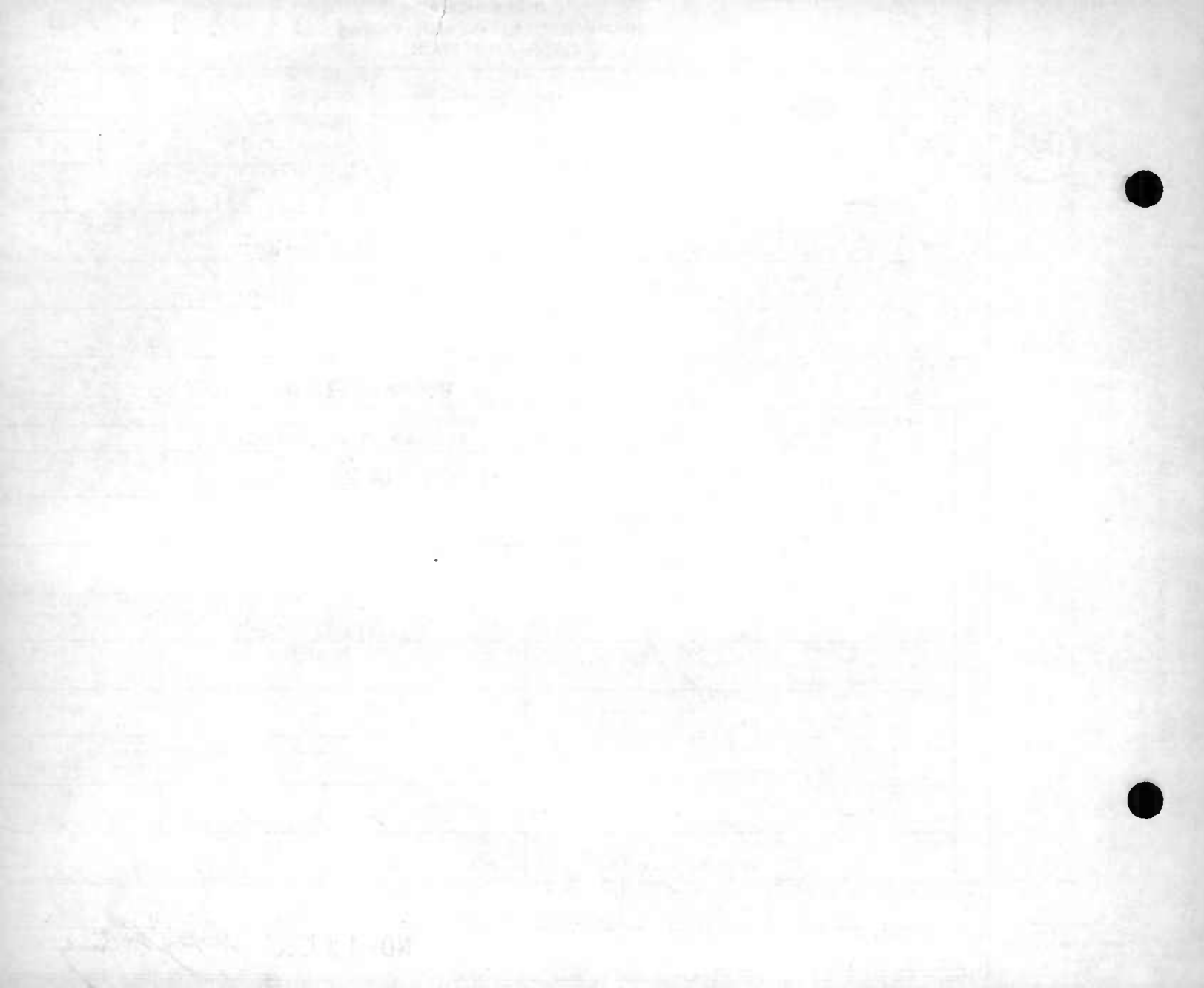
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MARY A. Voshell</b>			2a DATE OF DEATH MONTH DAY YEAR <b>11 10 80</b>			2b HOUR <b>7 A.M.</b>				
3 SEX <b>F</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>02 10 01</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.				
10 CITY OR TOWN OF DEATH <b>Cambridge Md.</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Camb. House Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>md.</b>			13b COUNTY <b>Talbot</b>		13c CITY OR TOWN <b>Cordova</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>Box 49 Rt. 1</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ulysess Voshell</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Hopkins</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. <b>217-48-7542</b>		17 INFORMANT ADDRESS <b>John U. Voshell see item #13</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Organic Brain Syndrome</b>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. Tanman</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-10-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. TANMAN</b>				22e. ADDRESS <b>17 Franklin St. Camb. Md. 21613</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-13-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot Md.</b>	
24 FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>				ADDRESS <b>Easton, Md.</b>		25 DATE RECEIVED BY REGISTRAR <b>NOV 13 1980</b>	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, AND PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <b>Bernard Edward Wazlawek</b>										2a. DATE KNOWN OF DEATH <b>11-29-80</b>	
3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>8/29/34</b> 6. AGE (IN YEARS) <b>46</b> 7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> 8. IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>										2b. DATE OF DEATH <b>11-29-80</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b> 7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b>										2d. DATE PRONOUNCED DEAD <b>11-29-80</b>	
10. CITY OR TOWN OF DEATH <b>Vienna</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>R.F.D.</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STEEL</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>											
13a. STATE <b>MD.</b> 13b. COUNTY <b>Balt.</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>8021 Neighbors Ave.</b>											
14. FATHER'S NAME FIRST <b>EDWARD</b> MIDDLE <b>WAZLAVEK</b> LAST <b>VERONICA</b> 15. MOTHER'S MAIDEN NAME FIRST <b>HERMAN</b> MIDDLE <b>HERMAN</b> LAST <b>HERMAN</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>UNK</b> 16b. SOCIAL SECURITY NO. <b>220 305 737</b> 17. INFORMANT <b>Deputy Tall Dor. Co. Sheriff Off.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of brain</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>9222</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION <b>12N</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Shot by fellow deer hunter who tripped.</b> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>12N</b> 21b. TIME OF INJURY HOUR A.M. <b>11</b> MONTH <b>11</b> DAY <b>29</b> YEAR <b>80</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Shot by fellow deer hunter who tripped.</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <b>WOODS</b> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Nr. Besspich Vienna</b> 21f. LOCATION CITY OR TOWN <b>Dor.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>											
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John Mace Jr.</b> TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER DATE SIGNED <b>11/29/80</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace Jr.</b> ADDRESS <b>Cambridge, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> 23b. DATE <b>12/3/80</b> 23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL</b> 23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>											
24. FUNERAL DIRECTOR NAME <b>J.G. CONNELLY</b> ADDRESS <b>300 MACE</b> 25a. DATE <b>12/3/80</b> 25b. REGISTERED SIGNATURE <b>[Signature]</b>											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

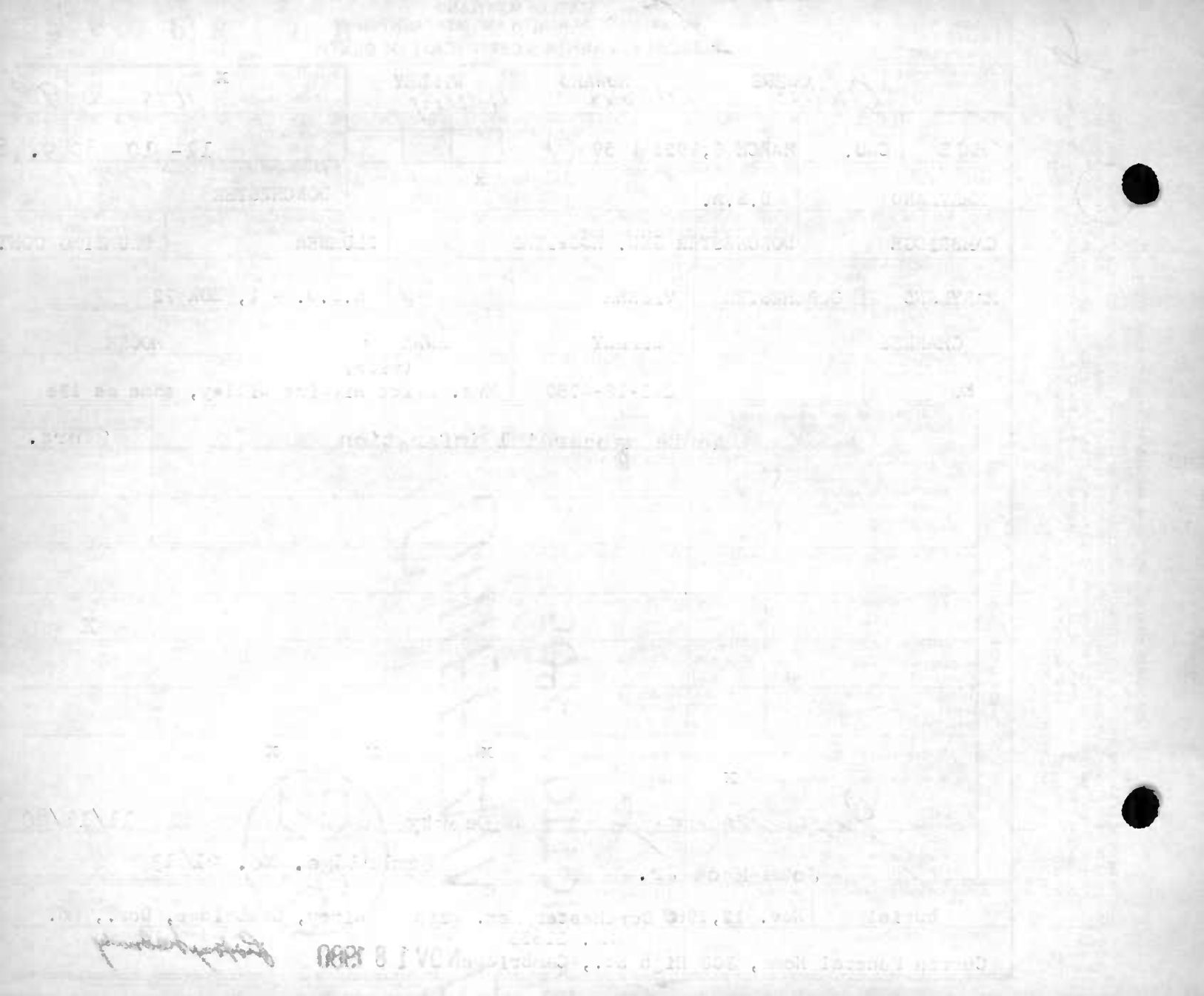
BP  
DHMH - 17  
(VRA15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST OWENS		MIDDLE EDWARD		LAST WILLEY		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR MARCH 6, 1921		6. AGE (IN YEARS) LAST BIRTHDAY 59 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11- 10 19 80		2d. HOUR 9:46 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.	
10. CITY OR TOWN OF DEATH CAMBRIDGE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLUMBER				12b. KIND OF BUSINESS OR INDUSTRY PLUMBING CONT	
13a. STATE MARYLAND				13b. COUNTY DORCHESTER		13c. CITY OR TOWN VIENNA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.F.D. # 1, BOX 72			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES WILLEY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA MOORE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-18-4780		17. INFORMANT (wife) Mrs. Alice Higgins Willey, same as 13e				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John Mace Jr.</i>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 11/11/80	
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr.				ADDRESS Cambridge, Md. 21613									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE Nov. 12, 1980		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Airey, Cambridge, Dor., Md.			
24. FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St., Cambridge				ADDRESS Md. 21613		25a. DATE REC'D. BY REGISTRAR NOV 18 1980				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Shannon Marie Willey</b>			2a. DATE KNOWN OF DEATH MONTH <b>11</b> DAY <b>14</b> YEAR <b>1980</b>		2b. HOUR <b>AM</b>
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>1</b> YEAR <b>1980</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>2</b> MONTHS <b>11</b> DAYS <b>14</b>	IF UNDER 1 YR. MONTHS <b>2</b> DAYS <b>14</b>	IF UNDER 24 HRS. HOURS <b>14</b> MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DOA Dorchester General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Cambridge</b>	
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>		15. MOTHER'S MAIDEN NAME FIRST <b>Rhonda</b> MIDDLE <b></b> LAST <b>Willey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Rhonda Willey</b> ADDRESS <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7980</b> <del>UNKNOWN</del> <b>S.I.D.S.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b></b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b></b>		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John Mace Jr.</i>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>11/17/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace Jr. M.D.</b>		ADDRESS <b>Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/17/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cem.</b>	
24. FUNERAL DIRECTOR NAME <b>Curran Funeral Home</b> ADDRESS <b>Cambridge, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1980</b>		25b. REGISTRAR'S SIGNATURE <i>P. J. H. H. H.</i>	
23d. LOCATION CITY OR TOWN <b>East New Market</b> COUNTY <b>Md.</b> STATE <b>Dor.</b>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



NOV 8 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 8 8 9 4	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Joseph W. Wilson</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>11-21-80</i>		2b. HOUR <i>3:40 AM</i>	
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1-3-1901</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD.		
10. CITY OR TOWN OF DEATH <i>Cambridge</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Dor</i>	13c. CITY OR TOWN <i>Cambridge</i>	13d. STREET ADDRESS <i>Rt. # 3 Beckwith</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph W. Wilson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lydia - Nichols</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-36-1876</i>		17. INFORMANT (Sister) ADDRESS <i>Estella Wilson Camden, N.J.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>UREMIA</i> <i>4039</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHRONIC NEPHROSCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wk</i> <i>9 mos</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>ARTERIOSCLEROTIC HEART DISEASE</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/30</i> , 19 <i>80</i> , to <i>11/21</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>11/20</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Alfred R. Maryanov</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>11/21/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALFRED R. MARYANOV</i>		22e. ADDRESS <i>610 RALE ST, CAMBRIDGE, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/25/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Beckwith Cem.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Beckwith, Dor, Md.</i>		23e. DATE RECEIVED BY REGISTRAR <i>NOV 20 1980</i>			
24. FUNERAL DIRECTOR NAME <i>L.H. Boardley</i>		ADDRESS <i>603 Washington St. Camb, Md.</i>		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



